Summary of the September 22, 2004 System Leadership Council Meeting

The following Council members attended this meeting.

Janet Areson	James L. Evans, M.D.	S. James Sikkema, LCSW
Steven J. Ashby, Ph.D.	Paul R. Gilding	Frank L. Tetrick, III
Jack W. Barber, M.D.	Catherine Hancock	William J. Thomas
Barbara Barrett	Cynthia B. Jones	James A. Thur, M.P.H.
Mary Ann Bergeron	Charlotte V. McNulty	Candace B. Waller
Charline A. Davidson	James S. Reinhard, M.D.	Joy Yeh, Ph.D.

Rosemarie Bonacum, Margaret Graham and Leslie Katz representing Dr. Diorio, James M. Martinez, Martha J. Mead, Will Rogers, and Joyce Willis, representing Dr. Modlinski, also attended the meeting. This summary lists key points discussed at the meeting; **decisions, agreements, and actions are shown in bold print**.

1. Last Meeting Summary and Current Agenda: The Council accepted the summary of its June 23 meeting and the agenda for this meeting, with one addition. The Child Abuse Prevention and Treatment Act, was added at the request of Jim Thur. Dr. Reinhard introduced two new Council members: Candace Waller, who has replaced George Pratt, and James Sikkema, who has replaced Lynn Chenault. Jim Martinez announced that the Department had submitted a System Transformation Grant, focusing on housing, with a recovery-oriented interagency approach. The Council asked for this to be on the agenda for its next meeting. Dr. Reinhard reminded the Council of its decision several meetings ago to focus on large policy issues, such as items 2, 3, and 8 on the current agenda, leaving operational and informational items to other mechanisms and groups in order to keep the agenda to only two or three major items. He observed that the agenda shows some "agenda creep" with information items.

2. Major Themes and Strategic Directions for the Integrated Strategic Plan (ISP)

   - Charline Davidson distributed two handouts: a draft outline of the ISP and Key Themes from the regional plans and special populations work groups. The ISP will have a five-year time frame and be a relatively short document. It will be integrated with the Comprehensive State Plan next year and serve as a transition document for the next gubernatorial administration.
   - Several items in the Key Themes handout were emphasized: training in Quality of Care; Medicaid policy, services, and eligibility in Partnerships; and public education and awareness in Education/Awareness. Another major area of concern involved various workforce issues.
   - Most recommendations related to the draft ISP outline focused on Accessing a Full Range of Consumer and Family-Centered Services, especially defining uniform service availability levels across the Commonwealth, providing resources necessary to maintain current services capacity, and expanding services capacity. A consistent theme emerged: the need for more resources to maintain current services and develop new services.
   - **The Council agreed that private psychiatric hospitals are an essential component of the services system and need to be sustained, or state psychiatric facilities may need to be expanded in the future.**
   - Dr. Reinhard emphasized the need to address critical issues and produce a clear and readable ISP. For example, the future role of state facilities and state facility infrastructure are critical issues. There has been no significant investment over the past 40 to 50 years in maintaining state facility buildings. Should we patch up existing buildings or rebuild some facilities? Do we want to replicate the current state facility system or have more of a community focus?
   - None of the regional plans proposed defined reinvestment projects; instead, they discussed expanding community capacity and continuing to downsize state facilities. No plan discussed state facility infrastructure issues. **Dr. Reinhard agreed to provide the Department's capital outlay presentation, prepared for the Secretary and Department of Planning and Budget (DPB), to the Council after the Secretary received it.**

- Although all of the regional partnership and special population work group plans are helpful, **the Council agreed on the need for a "core strategic vision and priorities" that guide and prioritize recommendations in the these plans to avoid an ISP that is so broad and all-encompassing that it loses its usefulness**. For example, are we committed to moving our system to a recovery model now or first to a public safety/safety net model, then to the recovery model? Public safety considerations can be a distraction from the long-term goal of a more community-based system of care. While public safety is critically important, the lay public thinks psychiatric beds are the only way to ensure it.
- As the system has narrowed its focus, due to the increasing presence of Medicaid as the predominant funding source and inadequate overall state and local government financial support, many individuals who would have been served in the past are not being served. We now have a two-tiered system, where Medicaid enrollees receive more services, and indigent individuals have lost access in many cases to services. There is a sense in some areas that reinvestment will no longer be enough, additional new resources will be needed.
- Attempting to espouse one vision statement for a system as diverse as ours without being too generic may be difficult. Regional identities and variances and different orientations or approaches among the three program areas (MH, MR, and SA) need to be reflected in the ISP.
- **The Council agreed that, along with promoting the vision of self-determination, empowerment, and recovery, the system still has a responsibility to continue providing a safety net. We need progressive reform, with a continued safety net until the reform is achieved that can serve as the new safety net. The Council also agreed to continue its discussion of critical issues for the ISP at its November meeting.** Department staff will meet with the regional leadership on October 21 to discuss the ISP.

3. Issues Related to Acute Bed Availability (Access and Alternatives) and Medical Clearance

- Council members mentioned a number of interrelated issues that complicate this matter. In some places, individuals who meet involuntary admission criteria are being released without admission, sometimes with only an agreed-upon safety plan, because of a lack of available beds. In other areas, it may take 20 to 25 calls to find an available bed. There is a widespread lack of community alternatives to hospitalization. In some areas, there are placements in a CSB's residential programs by CSBs from outside of the area without following the continuity of care procedures. Many more consumers who are totally new to the services system are now being served. Sheriffs and magistrates have concerns about the four-hour limit on ECOs and question whether medical clearances are always needed. In some parts of the state, population growth will require additional beds or other alternatives.
- **The Council agreed that the system has enough state facility beds, but additional state funds are needed to stabilize and preserve private sector beds in the community and to implement community alternatives such as crisis stabilization programs to relieve future pressures for additional beds.** State funds will be needed even if Medicaid reimbursement becomes available for crisis stabilization because of the large proportion of uninsured or medically indigent individuals, related in part to the very low Medicaid eligibility level in Virginia (only 85 percent of the federal poverty level). The Department's preliminary budget proposals for the next General Assembly contain a request for $8.7 million for crisis stabilization programs.
- A key theme emerged in the Council's discussion: continue to support existing private sector participation in the services system, maintaining those beds, while developing other community alternatives (e.g., crisis stabilization programs). In the short run, focus on maintaining current local bed capacity. In the long run, focus on building alternative community capacity that reflects regional needs and differences.
- **The Council agreed that the Integrated Strategic Plan should contain strong policy statements for mental health parity in private health insurance, adequate Medicaid rates, and coverage of individuals who are medically indigent or uninsured.**

- Medical clearance continues to be an issue in some areas. **It was noted that Will Pierce and Jerry Deans are working on standards for medical clearance at state facilities.** Will Rogers indicated that his CSB developed a list of standard tests for medical clearance and hospitals have been very receptive to it. **The Department is surveying state facility directors about medical clearance issues and agreed to provide the results to the Council.**
- The Department has been meeting with the Virginia Hospital and Healthcare Association to understand its concerns and challenges. One issue is the refusal of some nursing homes to readmit some patients after they have been treated in local psychiatric facilities. **The Department will be meeting with the Department of Health about nursing home obligations.**

4. Issues When Medication Management is the Only Service Received by a Consumer
   - The VACSB Executive Directors Leadership raised the issue of paperwork requirements and inefficiencies related to consumers who receive only medications. This group of consumers includes long-term CSB consumers, not just new individuals seeking free or low-cost medications. Most, if not all, CSBs have consumers who receive only necessary medications; that is all they need from the CSBs.
   - Issues related to the provision of medications will become even more exacerbated when the Department of Corrections (DOC) begins referring released inmates to CSBs for services. Currently, DOC cannot identify how many inmates may be referred.
   - **The Licensing Office has developed a minimum set of requirements for the individualized services plan for consumers who are receiving only medications. The Council agreed that this information should be provided to all CSBs.**
   - **The Council also agreed that, despite this somewhat abbreviated set of requirements, licensing requirements for medication only services should be streamlined as much as possible. The Council referred this issue to the VACSB Regulatory Committee, chaired by Joseph Hubbard, for follow up with the Department's Office of Licensing.**

5. State Pharmacy Issues
   - The Department included $4.2 million for the state pharmacy shortfall in FY 2005 as part of its preliminary budget requests for the next General Assembly.
   - Several concerns were expressed about the availability of information about the Department's Pharmacy Work Group and the state pharmacy budget situation and how this information is communicated to CSBs. **The Department agreed to provide monthly updates to all CSBs about the state pharmacy budget situation and other pharmacy issues such as preferred drug list** (**PDLs) and Medicaid. This information could be placed on the Department's web site.**
   - Cynthia Jones noted that the DMAS web site has information about DMAS' PDL. Anti-psychotic medications will not be included on the PDL. SSRI medications are being considered for inclusion on the PDL. The new Medicare Part D drug benefit is very complicated; all 50 states are working together on how to implement it; and it may be impossible to do so by the target date, January 1, 2006. Questions about Part D should be referred to Cynthia Jones.
   - Dr. Evans informed the Council that the Work Group is proposing a Pharmaceuticals and Therapeutics Committee. In response to a concern that the Pharmacy Work Group was focused on reducing costs but not on standards of care, Dr. Evans indicated that it was very oriented to quality services.

6. Approach to Address the Eight Items in Section 10 of the FY 2005 Performance Contract: **The Council referred these eight items to the Community Services Performance Contract Work Group, chaired by Demetrios Peratsakis, for resolution.** That group is working on the FY 2006 performance contract and would be the best group to address the status of these items.

- Operational Framework
- Systematic Procedures
- Systemic Outcomes
- Billing Consumers
- Priority Populations
- Discharge Planning Protocols
- Discharge Assistance Project
- Co-Occurring Disorders

7. December Governor's Conference Update

   - Martha Mead distributed the brochure and draft agenda for the conference, which will be held on December 9 and 10 at the Sheraton West, on Broad Street at I-64. Attendance is expected to be 300 to 400 people; consumer scholarships will be available. The theme of the conference is Envision the Possibilities: Self-Determination, Empowerment, and Recovery.

   - The conference agenda is still being developed by the Conference Planning Committee, which has worked with all three program areas (MH, MR, and SA) to develop an agenda that addresses criminal justice, children's, and other issues that cut across those areas. The Integrated Strategic Plan (ISP) will be discussed at the conference.

8. Shift of Medicaid-Funded Services Toward a Transformed Community-Based Recovery Emphasis

   - Medicaid was established as a medical program, and, while it has been transformed to some extent to a rehabilitation program, it is still a medical program. Peer support is currently not covered in the State Medical Assistance Plan, but it could be if appropriate funding were available. DMAS is looking into this.

   - Cynthia Jones asked for a couple of representatives to meet with Diana Thorpe at DMAS about covering 24-hour general supervision. Lee Price and Mary Ann Bergeron were named as the representatives. It would be helpful to articulate how covering 24-hour supervision relates to supporting recovery and self-determination.

   - Catherine Hancock informed the Council that CMS has approved the revised community mental health regulations. There are many positive changes, including a recovery focus. DMAS will distribute manual changes in November.

   - Cynthia Jones indicated that the May 24 CMS letter about Medicaid coverage for inmates of institutions is still being reviewed by DMAS. The message from CMS seems to be that it will not pay for this. DMAS needs CMS to decide that this is not a federal financial participation issue.

   - There is a meeting on October 13 with the Secretary of Health and Human Services to reach agreement on MR Waiver start up funds. Cynthia Jones stated that DMAS and the Department are comfortable with this idea but need to check with DPB and the General Assembly money committee staffs about authority to use the appropriation for this purpose.

9. Child Abuse Prevention and Treatment Act: Jim Thur asked the Commissioner to express our deep concern to the Department of Social Services that it submitted the plan for this act without any involvement from the Department. This was characterized as a massive communications breakdown. Part C coordinators were informed about this, but CSB Executive Directors were never informed.

10. Schedule of Future Meetings

    - The Council adopted the following schedule of future meetings:

      November 3, 2004
      January 12, 2005
      March 16, 2005
      May 4, 2005
      June 22, 2005

    - All meetings will be held in Room C at Henrico Area Mental Health and Mental Retardation Services and will begin at 9:30 a.m. This represents a change in the meeting time from 9:00 a.m. to 9:30 a.m.